HMA President's Message

Carl W. Lehman MD

Medicare and Medicaid are entitlement programs that are of great concern to congressional leaders. In both programs, the numbers of beneficiaries and benefits are outstripping the money budgeted, with the grave possibility they will be bankrupt in a few years.

One significant problem that will affect the Medicare program is the projected marked increase of beneficiaries—the baby boomers—the 76 million persons who were born between 1946 and 1964. These individuals are just turning 50, and they will markedly affect the Medicare program in the next 15 to 35 years. The life expectancy of men is now 81 and women 85. Most likely the baby boomers born in 1960 will not received Social Security benefits until they're 67 years old. Today 33.4 million Americans are 65 years and older compared to the projected 59.4 million who will be 65 in 2030. Today those who are over 85 is about 3.5 million compared to the projected 5.8 million who will be 85 in 2035.

The boomers will be the first long-lived generation, the first to really get a taste of mass longevity. Boomers increasingly are splitting into two groups: the *haves* who tend to come from two-salary households with college degrees, and the *have nots*, the 45% with a high school diploma or less. About three-fourths of boomer women are in the labor force and will more than likely have their own pensions, as compared to their stay-at-home mothers. Unfortunately, the have nots, who will head toward retirement with low-wage jobs, low pensions, little or no health coverage, and minimal financial security by way of savings and home equity, will experience a gloomier picture. Today four workers support one Medicare patient, and by 2030 this ratio will be two to one.

If the Medicare program is to be preserved, a marked change in addressing Medicare issues must occur.

I agree with Dr Richard R. Kelley who recently wrote that during the past decade the power to make decisions about the delivery of health care has become more and more concentrated in the hands of bureaucrats and corporate executives who have become the *customer* and consumers seeking health care are told which doctors they can see, what services they can have, and when they can leave a hospital. Citizens should be allowed to receive health care funds tax free. Medicare and general health care reform should include this provision which would allow both employees and retirees to set up tax-free health care savings funds and buy health care insurance and/or health care directly from providers. The marketplace will rule as smart comsumers seek the best services. The reverse is happening now. Government bureaucrats and corporate accountants select health care providers, dictate fees, services, and availability. Health maintenance organizations are slashing fees paid to doctors, and hospitals are refusing to do business with those who will not abide by the reduced payment schedules and reduced services offered to patients.

In order to control the appropriate use of Medicare benefits, the system must reward those who do not waste or demand overuse of the system.

The use of medical savings accounts for Medicare recipients is one suggested option. All appropriate and necessary care would be provided and futile activities would be eliminated. Management costs must be minimized, thereby allowing maximal funds for patient care.

Medical School Hotline

The Role of Speech-Language Pathologists and Audiologists in Medicine

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The role of the speech-language pathologist and audiologist in medicine is evolving at a pace comparable to that of the health care system in general. The professions are responding to internal and external demands for increased efficiency and effectiveness. Over the past few decades, speech-language pathologists and audiologists have grown from peripheral contributors of health care to the principal source of diagnostic, evaluation, and (re)habilitation services for speech-language-hearing-related disabilities.

Historically, speech-language pathologists and audiologists have enjoyed at least three roles in health care delivery:

- Early audiologists and speech-language pathologists served as allied health practitioners, generally in hospitals or office practices, working under general medical supervision, sometimes by prescription. This role is diminishing rapidly.
- Speech-language pathologists and audiologists became established as the primary experts in issues specific to speech-language-hearing disorders and their nonmedical diagnoses, evaluation, and treatment.
- They became the referral resource for diagnosis, management, and treatment of speech-language disorders (speech-language pathologists) and for the diagnosis, evaluation, and treatment of hearing disorders (audiologists).

The evolution has been driven by advances in medicine in general, the qualitative improvement of services provided by speech-language pathologists and audiologists, and vastly increased consumer awareness and demand.

Advances in medicine and health care have resulted in more medical survivors including:

- Greatly reduced infant mortality with an unfortunate side effect of increasing the numbers of children requiring intervention for speech-language-hearing disorders.
- Higher survival rates in accident and injury with residual speech-language-hearing and balance disturbances.
- Increased realization of full life expectancy in the country in general and Hawaii in specific along with the maturation of the baby boomers. The extended longevity in our population has vastly increased the demand for services to the geriatric population.

Infants and children may evidence delayed development of speech and language, stuttering and, less frequently, voice disorders. Middle ear disorders are common in the early years and have significant impact on language development. The incidence of hearing loss due to nerve damage in children and teenagers is increasing after two decades of decline. Ninety percent of children diagnosed with learning disabilities have language disorders.

Adults and young adults with speech-language-hearing disorders are at risk of social, emotional, intellectual, and economic impairment in an expanding technology-driven world. Adequate language and communication ability are a necessity.

Adult-acquired speech-language disorders range from voice disorders from vocal abuse or irritants to speech-language deficits

related to hearing loss and partial or complete loss of expressive and/or receptive language in stroke or traumatic brain injury. Tens of millions of adults have disorders of hearing and the losses tend to be progressive with age.

In the geriatric population, language and hearing disorders predominate with severity often related directly to general health, social and intellectual function, and independence.

The program in speech pathology and audiology at the John A. Burns School of Medicine is an active participant in the efforts to adapt the delivery of services in speech-language-hearing to today's and tomorrow's health care needs. Part of that effort is to help define and model a system that assures availability, access, and quality of services at the earliest possible moment.

Today we are seeing our roles evolve in support of health care initiatives. Speech-language pathologists and audiologists not only provide independent diagnostic, evaluation, and treatment services, but are becoming consultants in speech-language-hearing. This new role extends the services of the referring party. Speech-language pathologists and audiologists provide the managing physician with diagnostic and evaluative information of value in decision making and preparing treatment plans.

Military Medicine

The Evil Empire Revisited
Operation Provide Hope VI

MAJ Brian Crisp MD

After the fall of the Soviet Union and its subsequent dissolution, U.S. Vice President Al Gore and Russian Prime Minister Viktor Chernomyrdin met and agreed to specific methods by which the U.S. could aid the struggling new nation. Pursuant to and as part of this agreement, the U.S. Army, Pacific (USARPAC) was asked to deliver excess Army medical materiel (in essence, a now obsolete but never used field hospital) to City Hospital No 2 in Vladivostok, Russia, located on the Sea of Japan. This previously *closed* city was considered so secret and of such vital military importance that even bona fide Soviet citizens had to apply for a special permit to visit friends or family members residing there.

The mission was comprised of three phases. In the first phase, team members of the ad hoc Medical Logistics Support Team, or MLST, met at Sagami Army Depot in Japan (where the field hospital was stored) for initial planning. Personnel for this phase from Tripler Army Medical Center included staff family physician MAJ Gary Clark and dentist CPT Chris Evanov. They were met by a host of biomedical repairmen, logistical, supply and engineering specialists, and linguists who were drawn from as far away as Pennsylvania and as close as Camp Zama, Japan. Following the initial planning meeting in Japan, the members traveled to Vladivostok where they inspected City Hospital No 2 and made final plans as to what to bring, where to place it, and how it could best be used. While there, they discovered another hospital in need of American help, the Children's Tuberculosis Hospital. This hospital looks after some of the poorest of Vladivostok's children; kids who not only have TB, but who are typically from unhappy homes—often riddled with alcoholism, neglect, and abuse. These children usually live in the TB Hospital for up to a year and a half while undergoing treatment, in conditions that would bring tears to most adults—as it did to most of our team. After assessing the two hospitals, the team returned to Japan where much of the equipment that would be sent was located—this completed phase I. Phase II consisted of uncrating, inspecting, testing, and repacking all medical equipment to be shipped to Russia. Sixty-two containers of this medical equipment were then loaded onto a cargo ship and transported to Vostochny, the civilian port about two hours north of Vladivostok.

After the equipment arrived, Phase III began: installation, assembly, and use of the donated supplies. On a team of 33, 11 Tripler personnel went to Russia for this phase, including optometrist CPT Patricia Hill, Dr Evanov, and me. The remainder of the team was logistical, biomedical, engineering, laboratory, x-ray, respiratory, and operating-room specialists. As the only physician on the mission, my job was to act as medical advisor and guide. Additionally, I was assigned the responsibility of medical education; that is, I was in charge of the overall hands-on instruction, written instruction, and videotaping of selected medical equipment. And, I was the medical support for our team members in case of illness or injury.

After an overnight stay in Tokyo, I arrived in Vladivostok via Aeroflot—on an aircraft replete with smelly chairs, bad food, and gum on the carpet that sticks to the bottom of your shoes. This was especially poignant after flying out of Tokyo's Haneda airport (probably the cleanest airport in the world), and Toyama airport on Japan's western coast (the second cleanest). Just like the old movies, I was pulled out of a line of passengers when I showed the immigration officers my official American passport and was forced to wait an additional half-hour until I was cleared, ostensibly from Moscow. Old habits die hard.

After getting settled in our home-away-from-home for the next six and a half weeks, I toured the hospital and had a chance to see its operating rooms, intensive care unit, pediatric service, and the various wards. I also viewed the ancillary services, such as x-ray, physical therapy, dentistry, laboratory, and the morgue (a hideous place—right out of your worst childhood nightmares). We quickly went to work locating equipment (one of the hardest jobs), then assembling, checking, rechecking, and finally instructing our Russian counterparts in their use. We also translated instructions into Russian to be attached to the various pieces of equipment. All manner of obstacles were encountered, from the Russian professor who "had 20 years of medical education and could *certainly* put together a bed" (he put it together backward), to various Russian nurses and doctors hoarding equipment they had absolutely no use for, to oxygen wall flow rates that were inappropriately low for some of our anesthesia equipment and precluded their use. The bigger pieces of equipment, such as x-ray or laboratory pieces, were easily distributed to the appropriate personnel, but it was much more difficult for some of the smaller supplies. What would typically transpire was that one or more of the team members would open a *multi-pack*, a roughly 6 x 6 x4-foot container containing a multitude of almost every medical product available. A gaggle of about 8 to 10 Russian nurses and physicians would gather around and *claim* each piece as it was presented and interpreted by the interpreter. As one might expect, however, some medical items defy translation, eg, how do you say "Kirschner wires" or "cerebella support" in Russian? Many boxes had to be opened by the Russian personnel and visually inspected to determine their appropriate destination. After that, piles of equipment would be loaded onto antiquated gurneys and wheeled, we hope, to the right location.

One way or another, the equipment made its way to the appropriate department and was installed. The Russians were instructed in its use and even starred in the instructional videos. Late nights and working weekends saw to it that all translations were completed